public hospitals in order to ensure the continued existence and stability of these core providers who serve the Medicaid population. The total payments will not exceed the aggregate 150% UPL amount for all in state and out of state non-state owned public hospitals for inpatient services. These lump sum pool payments will be paid during the federal fiscal year, beginning with federal fiscal year 2001.

C. Inpatient UPL Charge Requirement

The inpatient lump sum payments identified in B above will be added to the projected Medicaid inpatient revenue as reflected in A.3. above to ensure that total Medicaid inpatient payments will not exceed Medicaid inpatient charges of each non-DSH South Carolina non-state owned public hospital. To project Medicaid inpatient charges through FFY 2001, each non-DSH South Carolina non-state owned public hospital's FY 1998 Medicaid inpatient charges will be trended forward based on MARS Report Medicaid inpatient charge information. MARS reports for each non-DSH South Carolina non-state owned public hospital's fiscal year will be generated for fiscal years 1999, 2000, and 2001 to determine the percentage increase in Medicaid inpatient charges from year to year. The percentage increase/decrease will be based on the increase/decrease in charge per day since the 1998 base year.

IX. Changes to the Prospective Payment Rates

A. Future Redetermination of Prospective Payment Rates

1. In future years, prospective payment rates for acute care facilities will be established by trending forward the base year prospective payment rates by applying an inflation factor, as defined in Section IV, for the prospective payment year.

2. The outlier set-aside, as described in Section IV of this plan may be recalculated periodically.

3. The DHHS will recalculate the base year prospective payment rates as the agency deems necessary. Recalculation of the base year may involve recalibration of the relative weights, use of a more recent cost report base year or both.

4. The DHHS may recalculate the psychiatric residential treatment facility per diem rate each year based on a prior year's cost report data.

B. Rate Reconsideration

1. Providers will have the right to request a rate reconsideration if one of the following conditions has occurred since the base year:

   a. Changes in case-mix since the base year. Such requests will be accompanied by documentation of the case-mix change using DRG case-mix index and severity of illness measures. Use of the DRG case-mix index alone is not satisfactory for rate reconsideration under this part. The severity of illness study may be based on a statistically valid random sample of Medicaid patients treated in the facility on an annual basis. If a sample is used, the sampling methodology including the standard error value will be included in the documentation.

   b. An error in the facility's rate calculation. Such request will include a clear explanation of the error and documentation of the desired correction.

   c. Extraordinary circumstances, such as acts of God, occurring since the base year and as defined by the DHHS. Such requests will be submitted along with documentation that clearly explains the circumstance, demonstration that the circumstance was extraordinary and unique to that facility, and the expenses associated with the circumstance.

2. Rate reconsideration will not be available for the following:

   a. The payment methodology, case-mix adjustment, relative weights, inflation indices, DRG classification system.

   b. Inflation of cost since the base year.

c. Increases in salary, wages, and fringe benefits.

3. Requests for rate reconsideration will be filed in accordance with procedures described in the Rate Reconsideration Manual that can be obtained upon request, from the Division of Acute Care Reimbursement. Rate reconsideration requests will be submitted in writing to the DHHS and will set forth the reasons for the requests. Each request will be accompanied by sufficient documentation to enable the DHHS to act upon the request. Rate reconsiderations for errors in the facility's rate will be submitted in writing within 30 days of the rate notification.

4. The request will be forwarded for review to the Division of Acute Care Reimbursement. This Division will review all requests for rate reconsideration and will issue a decision in writing to the provider.

5. The provider will be notified of the DHHS's decision within 90 days of receipt of the completed requested.

6. Pending the DHHS's decision on a request for rate reconsideration, the facility will be paid the prospective payment rate currently in effect, as determined by the DHHS. If the reconsideration request is granted, the resulting new prospective payment rate will be effective the later date of:

   a. The receipt of the request and supporting documentation requested by panel; or

   b. The first date of the prospective rate year, should the rate reconsideration be granted before this date; or

   c. The date on which the asset leading to the expenditure was placed into service.

7. In no case will a rate reconsideration revision be granted if it will result in a facility's reimbursement exceeding what would have been paid under Medicare principles of reimbursement.

8. Rate reconsiderations granted under this section will be effective for the remainder of the prospective rate year. Requests and documentation will be kept in a facility file and may be automatically reviewed in the following year if the panel has determined that the condition will continue to exist. The facility will be asked in future years to supply only necessary updated information.

9. Psychiatric residential treatment facilities may request a rate reconsideration within 30 days of receiving their rates. The rate reconsideration may be filed for the following circumstances:

   a. An error in the facility's rate calculation.

b. Amended costs and statistics submitted within 30 days of the receipt of notification of rates.

C. Appeals

1. A provider may appeal the DHHS's decision on the rate reconsideration. The appeal should be filed in accordance with the procedural requirements of the South Carolina Administrative Procedures Act (SCAPA) and the DHHS's regulations.

2. A provider may appeal the Capital and/or Direct Medical Education Final Settlement. The appeal shall be filed in accordance with the procedural requirements of the SCAPA and the DHHS's regulations.

X. Review and Reporting Requirements

A. Utilization Review Specific to Prospective Payment

1. Utilization Review will be conducted by the state or its designee. Utilization review conducted by the designee will be performed as outlined in the current contract.

2. Negative review findings are subject to payment adjustment. Hospitals that develop or show trends in negative review findings will be subject to educational intervention.

B. Cost Report Requirements

Cost report requirements under the hospital prospective payment system will conform to Medicare cost reporting principles and use as their basis the Medicare Cost Report Form - HCFA-2552. In addition, inpatient providers must comply with Medicaid specific cost report requirements as published by the DHHS.

1. Acute Care Hospitals

a. All acute care hospitals contracting with the SC Medicaid program must submit the HCFA-2552 cost report form within one hundred and fifty (150) days of the last day of their cost reporting period (or by the Medicare due date when an extension is granted by the Medicare program). Only hospitals with low utilization (less than 10 inpatient claims) will be exempt from this requirement.

b. Cost report data may be used for future rate setting, cost analysis, disproportionate share purposes and inpatient capital cost settlements. Effective October 1, 1999, SC Department of Mental Health hospital cost reports will be used for annual retrospective cost settlements.

c. Medicaid inpatient capital cost will be retrospectively settled. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000. In accordance with OBRA 1993 requirements, disproportionate share hospitals will not be eligible for cost settlements since they will receive payment for 100% of their unreimbursed SC Medicaid cost through the SC DSH program.

d. Administrative days and associated cost, charges and payments will be reported on a supplemental worksheet issued by the DHHS. These days, cost, charges and payments must remain separate from all other Medicaid reported data. There will be no settlement for administrative days.

2. Psychiatric Residential Treatment Facilities

All psychiatric residential treatment facilities will submit the HCFA-2552 form as well as a certified audited financial statement. The HCFA-2552 will be completed using each facility's fiscal year statistical and financial information. Each facility will be required to submit these documents within one hundred and fifty (150) days of the last day of their cost reporting period.

C. Audit Requirements

All cost report financial and statistical information as well as the medical information contained on claims, is subject to audit by the DHHS or its designee. The audited information may be used for future rate calculations, inpatient capital and direct medical education cost settlements, disproportionate share program requirements, utilization review contractor requirements and other analyses.

1. Cost reports of non-disproportionate share hospitals will be desk-audited in order to calculate capital cost settlements. Capital cost will be settled at 100% of total allowable Medicaid inpatient capital cost for service dates on or after October 1, 2000, and may be processed within 2 years after the end of a hospital's cost report period. Capital cost will be settled at 85% for service dates prior to October 1, 2000.

2. Supplemental worksheets submitted by hospitals qualifying for disproportionate share payments will be reviewed for accuracy. No additional payments will be made as a result of these reviews. Adjustments will be made only when reviews uncover overpayments or result in loss of disproportionate share status.

3. Medical audits will focus on the validity of diagnosis and procedure coding for reconciliation of appropriate expenditures made by the DHHS as described in A of this section.

4. Retrospective cost settlements will apply to RTFs as follows:

   a. There will be no retrospective cost settlement for psychiatric RTFs when audited base year cost data is used to set the reimbursement rate.

   b. There will be a retrospective cost adjustment for psychiatric RTFs when an interim rate is set on unaudited base year cost data. If the interim rate includes subsequent period add-ons, a retrospective cost adjustment will be performed on this subsequent period cost. Only recoupments resulting from negative adjustments will be allowed.

   c. There will be a retrospective cost settlement for state owned and operated psychiatric RTFs. These will be settled at 100% of allowable cost.

   d. There will be no retrospective cost adjustment for RTFs that are paid the statewide average rate.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF SOUTH CAROLINA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE
(Reference Attachment 3.1-A)

2.a. OUTPATIENT HOSPITAL SERVICES

I. General Provisions

A. Purpose and Upper Payment Limit (UPL)

This plan establishes the methods and standards for reimbursement of outpatient hospital services. The plan sets a prospective rate of payment which will not exceed the upper limit of payment for comparable services furnished under comparable circumstances under Medicare as required by 42 CFR 447.321.

1. Effective August 1, 2001, non-DSH South Carolina non-state owned public hospitals will be eligible for a lump sum payment from a newly created Upper Payment Limit pool. In accordance with the revised Medicaid UPL requirements effective March 13, 2001, state Medicaid programs are allowed to reimburse non-state owned public hospitals up to 150% of their allowable Medicaid reimbursable cost for both inpatient and outpatient services. Separate aggregate UPLs are established for inpatient and outpatient services. The following methodology describes the method to be employed by SCDHHS in determining the non-DSH South Carolina non-state owned public hospital lump sum payment as it relates to outpatient services.

a. 150% UPL Pool

The following methodology will be used to determine the pool of funds available under the non-state owned public hospital outpatient UPL:

(1) The FY 1998 cost report period will be used as the base year in the determination of the 150% outpatient UPL for non-state owned public hospitals.

(2) The FY 1998 Medicaid outpatient charges will be multiplied by each non-state owned public hospital's FY 1998 outpatient cost-to-charge ratio. This will establish each hospital's FY 1998 outpatient cost. Additionally, FY 1998 Medicaid outpatient trauma costs for Level I trauma hospitals (as defined under Attachment 4.19-A, Section VII A(2)) will also be included. In order to trend the FY 1998 cost forward to FFY 2001, the SCDHHS shall employ the mid-point to mid-point inflation method using the following CMS inflation factors:

2.80%	CY 1998
2.40%	CY 1999
3.90%	CY 2000
3.30%	CY 2001

SC: MA 01-010
EFFECTIVE DATE: 08/01/01
RO APPROVAL: MAR 15 2002
SUPERCEDES: MA 99-007

(3) Each non-state owned public hospital's Medicaid outpatient revenue will be determined through the end of FFY 2001 based on actual FY 1998 Medicaid outpatient revenue, plus projected Medicaid outpatient revenue received through September 30, 2001. Projected Medicaid outpatient revenue will include any rate increases since FY 1998, plus applicable small hospital access payments.

(4) Each non-state owned public hospital's unreimbursed Medicaid outpatient cost at 150% will be determined by subtracting the projected FFY 2001 Medicaid outpatient revenue, as defined in (a)(3) above, from trended FFY 2001 Medicaid outpatient cost at 150%, as defined in (a)(2) above. Both in state and out of state non-state owned public hospitals' unreimbursed Medicaid outpatient cost at 150% will be summed to determine the aggregate payment that can be made. This will represent the maximum additional lump sum payment that the SCDHHS can make under the new Medicaid UPL regulations.

b. Payments

Effective August 1, 2001, the SCDHHS will make lump sum payments from the 150% O/P UPL pool to all non-DSH South Carolina non-state owned public hospitals in order to ensure the continued existence and stability of these core providers who serve the Medicaid population. The total payments will not exceed the aggregate 150% UPL amount for all in state and out of state non-state owned public hospitals for outpatient services. These lump sum pool payments will be paid during the federal fiscal year, beginning with federal fiscal year 2001.

2. Effective October 1, 1999, the Outpatient Fee Schedule rates increased. The new rates can be found in the Hospital Manual. In addition, a portion of the small hospital access payment (see 4.19-A Section VI) will be allocated to outpatient services.

B. Objectives

Implementation of the reimbursement methodology provided herein has the following objectives:

- To contain growth in the rate paid for outpatient services.
- To encourage outpatient resources be used when they are appropriate substitute for inpatient hospital services.
- To discourage the inappropriateness of outpatient hospital resources as a substitute for physician office and clinic services.
- To ensure the continued existence and stability of the core providers who serve the Medicaid population.

C. Definitions

The following definitions shall apply for the purpose of reimbursement under this plan.

1. Outpatient - A patient who is receiving professional services at a hospital which does not admit him and which does not provide him room and board and professional services on a continuous 24-hour basis.

2. Outpatient services - Those diagnostic, therapeutic, rehabilitative, or palliative items or services furnished by or under the direction of a physician to an outpatient by an institution licensed and certified as a hospital. This service will include both scheduled services and the provision of service on an emergency basis in an area meeting licensing and certification criteria.

3. Surgical service - Surgical services are defined as the operative procedures set forth in the ICD - 9-CM surgical procedure codes. Emergency and non-emergency surgical services are included as surgical services.

4. Non surgical services - Emergency or non-emergency services rendered by a physician which do not meet the criteria for surgical or treatment/therapy/testing services.

   a. Emergency services - Services rendered to clients who require immediate medical intervention for an condition for which delay in treatment may result in death or serious impairment.

   b. Non-emergency service - Non-emergency services are defined a scheduled or unscheduled visits to an outpatient hospital clinic or emergency room where a professional service is rendered.

5. Treatment/Therapy/Testing service - Such services are defined as laboratory, radiology, dialysis, physical, speech, occupational, psychiatric, and respiratory therapies and testing services.

II. Scope Of Services

Effective with dates of service July 1, 1988, hospitals certified for participation under the Health Insurance for the Aged Program under Title XVIII of the Social Security Act and participating under the Medicaid Program shall be reimbursed for outpatient services rendered to eligible clients according to one of three types of outpatient services categories. These categories are prioritized as follows:

Surgical services

Nonsurgical services

Treatment/Therapy/Testing services

A. Surgical Services

1. Services Included in Surgery Payment

Surgical services shall include those outpatient services for which a valid ICD-9-CM surgical procedure code is indicated. For the purposes of reimbursement, surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, operating room,

recovery room, prosthesis, etc. Physician's services and observation room charges are not included and may be billed separately.

2. Payment Method

a. Surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. IC-9-CM surgical procedures shall be classified by procedures of similar complexity which consume a like amount of resources. An all-inclusive fee shall be established for each class.

b. Fees for surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM procedure codes which are not classified under the initial grouping of procedures will be assigned a class by DHHS. Professional medical personnel will be responsible for this function. A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple surgeries only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

B. Non-surgical Services

1. Services Included in Non-surgical Services Payment

Non-surgical services shall include those scheduled and unscheduled emergency or clinic visits to hospitals which do not meet the criteria for surgical services, but which involve a professional services or direct patient contact other than that associated with a treatment/therapy/testing services. For purposes of reimbursement, non-surgical services shall be all-inclusive of the services rendered, including but not limited to drugs, anesthesia, IV, blood, supplies, nursing services, emergency room, clinic, etc.

Physician services and observation room charges are not included and may be billed separately.

1. Payment Method

a. Non-surgical services shall be compensated based on the lesser of the charge for services or an all-inclusive fee. ICD-9-CM disease classifications shall be grouped by procedures of similar complexity which consume a like amount of resources. An all inclusive fee shall be established for each class.

b. Fees for non-surgical classifications are based on a relationship to the average historical payment made by the state of such procedures as determined from claim history data. ICD-9-CM diagnostic procedure codes which are not classified under the initial grouping of procedures will be assigned a class by the Commission. Professional medical personnel will be responsible for this function.

A procedure may be assigned to an existing classification or a new classification may be created to compensate for the procedure at the discretion of DHHS.

c. In the case of multiple diagnosis only one payment will be made. The class producing the highest rate of payment will be selected as the payment rate.

C. Treatment/Therapy/Testing Services

The methods and standards for payment of treatment/testing/therapy services are divided into two categories:

- Laboratory and Radiology
- Other Treatment, Therapy and Testing Services

1. Laboratory and Radiology

a. Services Included in Payment Amount

Payment for laboratory and radiology services rendered to outpatients shall consist of a fee for services. The fee excludes payment for services rendered directly to a patient by a physician (professional). If laboratory and radiology services are combined with surgical or non-surgical services, no separate payment shall be made.

b. Payment Method

i. Payments for technical radiology and laboratory services shall be made based on the lesser of the charge or fixed fee for each CPT coded procedure.

ii. The fee for technical radiology or laboratory services is based on a percentage of the amount for a total procedure on the fee schedule for independent radiology or laboratory services.

2. Other Treatment, Therapy and Testing Services

a. Services Included In Payment Amount

Treatment, therapy, and testing services under this part include dialysis treatment, respiratory, physical, speech, occupational, audiological therapies, psychiatric treatment and testing. The payment for each treatment and testing category is a payment per service. Therapy services rendered under this part include the professional services component. If such services are provided in conjunction with surgical or non-surgical services, no separate payment shall be made.

b. Payment Method

Services under this part shall be reimbursed the lesser of the charge for the service or the fixed fee. A fixed fee is assigned for each service type under this part.

III. Utilization Review

1. DHHS shall review the medical necessity of all services rendered under this part. Such review may occur on a pre-or post-payment basis or, at the options of DHHS may occur prior to the rendering of the service. Where such services are determined not medially necessary, payment shall be recovered using the most expedient means, or denied in its entirely.

2. DHHS shall also review the appropriateness of billing for all service types. Such review may occur pre- or post-payment and may produce payment denial or recovery by the most expedient means possible.